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SENATE BILL 756

By Beavers

AN ACT to amend Tennessee Code Annotated, Title 56, relative to the coverage by health benefit plans for certain procedures and treatments.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF TENNESSEE:

SECTION 1. Tennessee Code Annotated, Title 56, Chapter 7, Part 26, is amended by adding the following language as a new section:

(a) As used in this section:

(1) "Health benefit plan":

(A) Means any accident and health insurance policy or certificate; nonprofit hospital or medical service corporation contract; health, hospital, or medical service corporation plan contract; health maintenance organization (HMO) subscriber contract; plan provided by a Multiple Employer Welfare Arrangement (MEWA); or plan provided by another benefit arrangement, to the extent permitted by the Employee Retirement Income Security Act (ERISA) (29 U.S.C. § 1001 et seq.); and

(B) Does not mean individually underwritten health insurance policies, or policies or certificates covering only accident, credit, dental, disability income, long term care, hospital indemnity, medicare supplement as defined in § 1882(g)(1) of the Social Security Act (42 U.S.C. § 1395ss(g)(1)), specified disease, vision care, other limited benefit health insurance, coverage issued as a supplement to liability insurance, worker's compensation insurance, automobile medical payment insurance, or insurance that is statutorily required to be

contained in any liability insurance policy or equivalent self-insurance; and

(2) "Health insurance entity" has the same meaning as defined in § 56-7-109.

(b) For any procedure or treatment that is not covered in an insured's health benefit plan but is approved by the federal food and drug administration, a health insurance entity shall pay up to the maximum amount provided in the health benefit plan for an alternative covered procedure or treatment for the same underlying health issue. If more than one (1) covered alternative procedure or treatment is offered in the health benefit plan, then the health insurance entity must pay the maximum amount that would be due for the most expensive covered alternative procedure or treatment, but the health insurance entity shall not be required to pay an amount pursuant to this subsection (b) that exceeds the actual cost of the procedure or treatment selected by the insured.

(c) The coverage required by this section is subject to the annual deductible and coinsurance established for all other similar benefits within the health benefit plan. The annual deductible and coinsurance for the coverage required by this section shall be no greater than the annual deductible and coinsurance established for all other similar benefits within the health benefit plan.

(d) Notwithstanding § 56-7-1005, this section does not apply to any state or local insurance program, under title 8, chapter 27, or to any managed care organization contracting with the state to provide insurance through the TennCare program.

SECTION 2. This act shall take effect July 1, 2017, the public welfare requiring it, and shall apply to policies or contracts entered into or renewed on or after that date.